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Editor
CHARLES H. KEENE, M.D.
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Assistant Editor
GERTRUDE E. CROMWELL, R.N.
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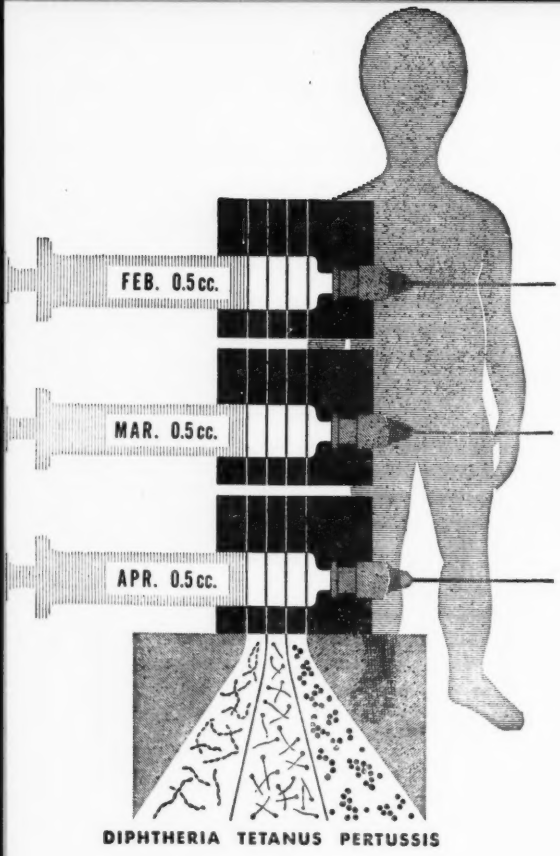

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THE JOURNAL OF SCHOOL HEALTH

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Vol. XIX OCTOBER, 1949 No. 8

FINDING THE CHILD WITH EYE PROBLEMS*

RICHARD G. SCOBEE, M.D.

Washington University, St. Louis, Mo.

Case-finding in children presents many more obstacles than case-finding in adults, for the simple reason that the children do not come to us—we must go to them. Children rarely complain, at least, not about diseases of the eyes. What we are especially concerned with at this time are those eye conditions which require attention and have but few symptoms. If we had to pick a single criterion in the light of our present knowledge, perhaps a child's grades in school would be a fairly good one. Any child who is not keeping up with his fellows deserves a complete ophthalmologic examination, and often we need go no further than that. There are often two reasons for poor grades in school: one is eyestrain, and the other I have chosen to call psychologic factors.

First of all, how may we recognize "eyestrain"? Eyestrain, according to the dictionary, is "the weariness or strained condition of the eye from overuse of uncorrected defects of vision." Children are rather notorious mimics. They form habits which frequently have no relationship to any need. Thus the child who puts his head down very close to his work often may not be doing it because of eyestrain. He may have discovered that it is one way to get attention. Certainly children's choices of seat location in the motion picture theater is no criterion, because they all go down to the front, and thus one might think they are all nearsighted. The fact that a child chooses to sit in the schoolroom as far back as possible from the teacher's watchful eye does not mean at all that the child is farsighted.

Children who blink a great deal often are thought by schoolteachers and anxious parents to be victims of eyestrain. Much more commonly they are victims of mimicry. Some adult, or some child

*Presented at the 1948 Conference of the National Society for the Prevention of Blindness held in Minneapolis, Minnesota. Reprinted by permission from the Sight Saving Review, Vol. XVIII, No. 4, p. 183.

**The author indicates that children with eye troubles can be discovered by observing behaviors and symptoms; testing for visual acuity; and checking for muscle imbalance.

in the classroom, whom they consciously or unconsciously admire may begin to blink; pretty soon Johnny comes home doing the same thing, and his mother is naturally quite upset.

I recall very well one day seeing a small boy about six years old who had a bright gleam of intelligence in his eyes. His mother was a large, obese and obviously very much perturbed woman. When she brought the boy in, I said to him, "Johnny, tell me how your eyes bother you."

Johnny looked at me and shook his head. I turned to his mother and asked, "How *do* his eyes bother him?" She was very upset and said, "Go on, Johnny; tell the doctor what it is that you do."

Johnny, with the ghost of a smile on his face, looked at me and said, "Doctor, every once in awhile I have to look down." He did it and his mother almost went into a spasm of anxiety. After sending Johnny out of the room, I explained to the mother that no particular disease was causing him to look down. Inquiring into the home situation I very soon found what had been at the root of the trouble, and I suggested that the application of a little child psychology might help.

Children do not complain of poor vision. If they happen to be nearsighted they don't know what there is to see, so they are not aware that they are missing something. If they happen to be farsighted they see as much as they can and they unconsciously stop paying attention when the strain becomes too great.

How about the impressions which the homeroom teacher gets of the child's eye condition or whether he needs eye care? One unpublished study reveals the rather interesting and surprising facts that her judgment as to which children have eyestrain is often wrong, and that she can be a very poor judge if she bases her conclusions on such factors as putting the head close to the work, blinking, and what not.

What criteria have we, then? At the present stage of our knowledge, if I were forced to pick a single criterion I would probably choose visual acuity—and visual acuity can be tested in any one of a number of different ways, on any one of a number of different charts.

A recent study completed by the Adjutant General's office in connection with the Vision Committee of the Army-Navy-National Research Council has shown one rather outstanding fact, namely, that from the standpoint of reliability—that is, reproducibility of scores from day to day—the familiar Snellen chart is as good as any other chart which has yet been devised.

There are inherent defects in every chart yet devised to test visual acuity. Some charts test pure resolution, to give it a fancy name—in other words, the child's seeing ability alone. That chart is rated rather high so far as visual acuity is concerned but it lacks certain phychological factors which are important. We can say, however, that at the moment a good test of visual acuity on a Snellen chart is a fairly satisfactory criterion. I should like to emphasize the word "good," for unfortunately not all tests for visual acuity, done on a Snellen chart, are *good*. Visual acuity tests, particularly those taken on children the first time they come to a clinic, have been found in our experience to be worth less than the paper on which they are written. Almost invariably we have found that the child, once we get him away from others in the clinic and retest him, has better visual acuity than reported in the clinic test.

Testing visual acuity is an art. There are many variables encountered. First of all, the child has to be familiarized with the test, and an experienced examiner can do this in a few minutes. The school nurse does not have the advantage that the private physician often has in getting the parents to work with the child at home and teach him something about the test. On the other hand, the nurse *does* have an advantage in that the parents are not present when the vision is tested.

The shy child has to be encouraged. The child who makes mistakes and is afraid of rules has to be made to understand that he may make mistakes, but that he must go ahead and try. The tester must be able to differentiate the rapid reader with good vision from the child who reads rapidly, but makes mistakes due to poor vision. Careless mistakes are of no particular significance.

Testing visual acuity must not be hurried. The child can sense when you are in a hurry, and as soon as he does you might as well quit the test then and there. I have watched visual acuity testing in some schools, and the process is one of lining up the children in the back of the room, the nurse having to make several schools that day. As the child comes to the front of the line he is asked to read the chart. There is obvious need for hurry. The children behind him are whispering and giggling and shuffling their feet and the nurse is trying to finish her task. Most of those results are worthless. A child who is to have his visual acuity tested should be alone with the examiner.

Testing visual acuity is not very difficult. It is simply the application of child psychology, and child phychology is nothing more than common sense when you come right down to it. Yet nowhere is child psychology ignored as much as in the field of test-

ing visual acuity. The child should be made to feel that the testing is a game—if possible, a contest—between himself and the examiner. If, for instance, the examiner says, "I'll bet you can't see the next line," which the child does, and the examiner urges, "Oh, shucks, try the next one," often the child goes much farther than might be expected.

Although the ophthalmologic examination of the 1,200 children to be studied in St. Louis is far from complete, we have already had numerous inquiries from health officers in other states. They are interested in getting some impressions, realizing that no results are yet available. In reviewing the data, it was surprising to note that in children who had some other condition, which required follow-up, there was frequently a slight difference in visual acuity between the two eyes—only one line. Thus a child with 20/20 in each eye is more likely to have "normal" eyes than one who has 20/20 in one eye and 20/15 in the other.

There are two possible causes for poor grades: one of these is faulty vision and the other may be considered psychologic. By this is meant primarily the impressions that children make on one another. The code of childhood is one of uniformity. We need only witness the popularity of saddle shoes and bobby sox, autographed sweatshirts, and girls wearing boys' shirts with the tails out, to realize that youth likes to act and dress alike. Youth likes to belong to youth, and that means belonging to the crowd and being like the crowd.

A cross-eyed child is obviously different from his fellows. He is not one of the group. Children can be unconsciously cruel by calling nicknames, and by omitting from games the child who is different. The child who is different, because his eyes are crossed, may take one of two ways out, or he may take any graduation between those two ways. One way out is to retire, to become shy, to withdraw from the group—not participating in their games—often seeking solace in books and becoming a bookworm. But making better grades than the others is poor compensation for being "different." The other extreme is to become a loud, noisy bully—dropping back a year or two to a group that is physically younger and smaller—so that the cross-eyed child can impose his will on the rest of the group simply because of his size. He grows up to be the loud, "life-of-the-party" adult. The development of these abnormal personalities—with psychologic scars on the personality—can be prevented if, early in life, the situation is corrected.

There is no problem about case-finding so far as the cross-eyed child is concerned. His defect is obvious. The difficulty is in trying

to convince the parents that something is wrong with their child's eyes. It is natural for parents to deny even in the face of obvious facts that their child has a defect. Once they realize the fact, and acknowledge it to themselves, they immediately seek advice. If the first advice they get is good, then their child is on the right track; but heaven help them if they go to someone who says, "Let's sit and wait—he may outgrow it." Much of the literature in the National Society for the Prevention of Blindness has emphasized the point that cross eyes cannot be outgrown.

There are two eye conditions in which the child's eyes are not obviously crossed—the tropias, which we call intermittent. The eyes are straight a fair amount of the time, but at times they turn either in, or out. Of the two types, the one in which the eye turns in intermittently has received much better treatment in the past than the type in which the eye turns out. This situation is due to the fact that many ophthalmologists recognize that often a child whose eyes occasionally turn in is farsighted; they recognize the association between accommodation and convergence. Generally the full correction of the hypermetropia will make the eyes stay straight.

Often the schoolteacher does not see the child whose eyes turn out, unless he is tired, because as a rule that symptom only occurs with fatigue; it begins by occurring only occasionally in childhood; becomes more frequent as the patient gets older and, by the time the adult has reached the age of 35 or 40, it may be constant. Reaching the child at an early age assures that he will have two seeing eyes working together when he grows up. Fusion, and getting the two eyes to work as a team, can be achieved in a five-year-old when often it is not possible in a patient who is 35.

In the past this intermittent exotropia has been labeled as a condition in which "if exercises do not help it, nothing can be done." Today we know that surgery offers an almost immediate and complete cure for this condition. If the deviation is marked, exercises will temporarily relieve the situation, but the child must continue with exercises for the rest of his life. Generally, if the exophoria or exotropia is greater than 18 prism diopters at the reading distance, the child, as a rule, will be benefited but not cured by orthoptics or eye exercises. Yet surgery offers a definite and permanent cure.

It is of interest to note that a one-eyed man never has headaches from eyestrain. It takes two eyes, because most headaches which are noninflammatory in origin come from trying to use two

eyes together, as a team. When patients with intermittent exotropia become tired and an eye turns out, all of their symptoms of eye-strain go away.

I saw a child last week in our school study who, while I was examining him, had one eye roll 'way out. I asked him if he had ever been taken to his family doctor, and he said, "Oh, yes, two years. They told my mother is was nervous." It was not nervous —it was non-nervous if it ever was anything, because the more nervous the patient, the less the eyes tend to turn out and the more they tend to turn in.

To sum up, case-finding in children resolves itself into: (1) observing behavior and symptoms in children: (2) testing for visual acuity; and (3) checking for muscle imbalance, which can have not only serious effect on the eyesight but on the personality of the child. The National Society for the Prevention of Blindness would be making an important additional contribution to sight saving in emphasizing the prevention of blindness which occurs in the unused eye when the cross-eyed child remains untreated.

International Council for Exceptional Children,—Dr. Elise H. Martens of the Federal Office of Education advocated a goal of at least 100,000 specially trained teachers for the nation's 4,000,000 handicapped children. Despite the fact that more than 150 colleges are offering at least one course in this field, fewer than 20,000 are at work now in special schools and classes for handicapped children. About 450,000 children are enrolled. Dr. Martens made a plea for reaching all of the 4,000,000 handicapped children. An intensified effort should be made to arouse young people with the desire to help handicapped children reach their fullest educational possibilities. Colleges and universities must have qualified staffs to prepare teachers for this important work. The public must be made increasingly aware of this need so that adequate funds will be provided for both teacher education and pupil instruction. Dr. Edgar A. Doll, director of research at the Vineland, N. J., Training School, said it was "cruel to hold out false hope to parents of gravely retarded" children. It was furthermore emphasized as being equally cruel not to provide proper care and training which would benefit the merely backward. The mentally retarded but normal could be trained to take and hold useful places in the community. Experience has amply demonstrated that public school provision for the mentally retarded has been found to pay big dividends. Abstract: Annual Meeting of the International Council for Exceptional Children, San Francisco. Abstracted by Frederick L. Patry, M.D.

HEALTH EDUCATION AND COMMUNITY ORGANIZATION*

C. E. TURNER, A.M., Ed.M., D.Sc., Dr.P.H.

Assistant to the President
National Foundation for Infantile Paralysis, New York, N. Y.

Projects of community organization and joint planning for health promotion are increasing rapidly in number and in scope. Health education is functioning increasingly through this medium. Our generation did not originate community planning. We are merely returning to it. It existed in very complete form in the town meetings of the early days; but communities gradually became so large and complex that the town meeting could not function. Now we are developing modern planning methods adapted to modern communities.

The health educator, the health officer, and the civic leader all see the need for community planning.

The health educator knows that the substance of education is learning, not teaching. It is not what the health expert says or writes which is important, it is what the public learns and does. Through community organization, lay and professional people study health problems; pool their knowledge and experience; and develop ways and means through which the problems are solved. This solving of health problems is the objective of community organization for health. The business of the health educator, like that of any good educator anywhere, is to facilitate the learning process. He has found that community organization provides a situation in which he can facilitate learning and constructive action on the part of important persons and groups.

The health officer realizes that health progress is based upon public understanding and public support. He has found that these often come most readily through community organization.

To the civic leader and intelligent citizen community planning is a natural and important part of the democratic process. Joint planning in which professional, lay, business, labor, agricultural, consumer, and other groups turn to a common interest, like health, and work out practical solutions for existing problems is one step in strengthening democracy. When people seek to solve their own problems with the help of government, instead of criticizing government for failing to do everything for them, they come to appreciate the nature, freedom, and functioning of the democratic process.

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*Read before the Public Health Education Section, A.P.H.A., November 9, 1949.

This discussion of health education and community organization is based in part upon the speaker's personal experiences, but in large measure upon two group adventures into this field in which your speaker has participated. The first was the work of the Committee on Community Organization for Health Education of this Association which surveyed early developments in community organization and published its report in 1941, the field work having been done by Mr. Philip L. Riley. That report told the story of 70 local programs in community organizations and two state programs.

Some of those programs had been developed under school leadership, some under health department leadership, some upon the initiative of voluntary health agencies and some under joint sponsorship. The report emphasized the relationship between school health education and public health education; showed how community organization furthers the solution of health problems; and reflected the value of cooperation between school, public health, and voluntary health agencies. It showed how community organization develops and how it functions in health promotion.

The second project was the work of the section on "Planning for State and Community Health," under the chairmanship of Dr. Florence R. Sabin in the recent National Health Assembly. This Section discussed community health planning with relatively little emphasis upon school health, and presented examples of such planning in five local areas, eight states, and one interstate region. Dozens of similar projects are scattered over the country.

From the background of such experiences, let us try to assemble those facts and observations concerning the kinds of planning groups, their development, planning methods, functions, and difficulties which will reflect the present status of community organization for health and some of the underlying principles.

Kinds of Joint Planning Groups. Under such names as council, committee, board, federation or association, joint planning groups are developing in neighborhoods, towns, cities, counties, states, and the nation. The boundary of what constitutes a community is obviously not fixed.

Increasingly, new groups are assuming a broad function, including problems of social and economic well-being, instead of confining their attentions to health in the more restricted sense. Existing councils are tending to broaden their scope in this direction. Such a breadth of scope is reflected by our agency for cooperative international health planning, the World Health Organization,

in its definition of health as "complete physical, mental, and social well-being, not merely the absence of disease or infirmity".

We find many groups participating, including health departments, school systems, voluntary health agencies, medical societies, professional organizations, and consumers of health service like business, labor, agricultural and civic groups.

The nature of the organization is not fixed. Its structure is determined by the people who build it. Like a plant, the health or welfare council grows and flowers best by adapting itself to its particular soil and environment.

At the local level we may point out the following types of organization for joint planning in the field of health:

1. A school health council in which professional people in health and in education join with lay people in planning for health promotion, but restrict their activities to problems of school health.

2. The health council or health education committee of official agencies through which departments of local government, concerned with health, coordinate their health education and sometimes other health activities.

3. The health council of voluntary and official health agencies, established either independently or as a health division of a council of social agencies, where official and voluntary health activities are planned and coordinated.

4. The health council representing official and non-official health agencies and also civic or health-consumer groups, who work together in planning and developing health activities.

5. The health council made up of lay individuals and lay organizations only, which plan and promote health activities with the aid of official and unofficial health groups, bringing in professional consultants to aid in their discussions as necessary.

6. Welfare councils of lay and professional groups similar in composition to group 4, but organized to consider all problems related to the public welfare.

At the state level we find the following three types of organization:

1. A state health council representing only the official agencies.

2. A state health council representing both official and voluntary statewide health agencies.

3. A state health council representing official and voluntary health agencies together with lay and civic groups, the scope of which tends to broaden.

At the national level we find joint planning taking place in:

1. National conferences of official health agencies, like the Surgeon General's Conference and the Conferences of State and Provincial Health Officers.

2. The National Health Council, made up primarily of the national voluntary health agencies.

3. The National Conference for Cooperation in Health Education, made up of national official and voluntary groups in health and in education, and concerned only with health education problems.

4. The National Committee of Health Council Executives, made up of the executive officers of local health councils, for a consideration of council programs and methods.

5. The occasional conference of specialists and representative groups called by the national government, like the recent National Health Assembly and the various White House Conferences on specific health problems.

There is some relationship between the planning groups on these three levels. They are increasingly willing to seek and give advice to each other. State and national groups often help local groups by providing consultants. State groups often contain representatives from local groups or representatives from state-wide agencies who are familiar with local health council activities. These relationships are helpful; but it is important that each group on any one of the three levels remain autonomous. Health councils should be representative, democratic, functional, autonomous, flexible, and capable of broadening their scope and affiliations.

(*Continued in November Journal*)

* * * * *

Personal,—Amos L. Beaghler, M.D., retired as Director of Health of the Denver, Colorado, public schools, on June 28, 1949. He was the first Director of Health for the public schools of Denver, being appointed in 1923. He has held that office ever since until the date of retirement. Dr. Beaghler has been active in the American School Health Association ever since the group was organized as the American Association of School Physicians at Buffalo, New York, in October 1926. He is a past President of the American School of Health Association and received the Association William A. Howe honor award in 1948.—*C.H.K.*

THE SOCIAL HYGIENE FACTOR IN HUMAN RELATIONS

L. M. SMITH, M.D.
Director of School Health Service
Board of Education, Pittsburgh, Pennsylvania

The majority of physicians, clergymen, educators, and parents agree that a knowledge of the fundamental facts with regard to sex is an important part of an adolescent or pre-adolescent child's education. Misinformation or lack of information concerning any matter which vitally affects human relations does not improve the happiness, the safety, or the general welfare of a young adult. Practicing physicians have seen much unnecessary suffering among young adults which was directly or indirectly the result of adult bungling of matters concerning sex.

For several years there has been a large amount of talk on the subject, a great many meetings for discussion, frequent refresher courses, and a considerable amount of planning to bring social hygiene out into the light and treat the subject as an educational problem to be dealt with in our schools. If I were to select the point of greatest resistance and lack of cooperation in promulgating a better knowledge of social hygiene in family relations, I would say that our colleges and universities can be considered backward or overly conservative in preparing teachers of social hygiene. Sex education is a technical subject which requires special training. Our colleges and universities have failed in this project. Thousands of boys and girls have come and are coming to maturity each year without adequate education and guidance in social hygiene and family relations. When they are not properly taught while in school, they turn to any available source at hand for their knowledge on the subject.

Sometimes, but too rarely, children are fortunate enough to have progressive and informed parents. Sometimes a fine young physical education or biology teacher recognizes the need and makes the most of the preparation he has acquired on the subject to teach it to children who are under his guidance, but in most cases the young people are left to shift for themselves and fall into the hands of the sexually ignorant, sometimes maladjusted, and occasionally vicious and depraved person. Our universities and colleges should open their doors to prospective teachers, both men and women, so that their students may receive an adequate technical training in family life and education as a part of their established curricula.

Social hygiene is not well enongh organized or standardized. I do not know of one good general textbook on the subject which could be used by the teaching profession. In our colleges the study needs academic standards and credits as well as academic sanction and sponsorship. Teachers are ready for it. Parents are ready for it. Students want this knowledge and the public-at-large wants it taught. In the public schools of my city, ninety-eight and one-half per cent of all parents signed permission slips for their children to take the social hygiene course. The National Congress of Parent-Teacher Associations, our various civic clubs and similar organizations, and our churches already stand behind it and support a social hygiene program. The bottle-neck is lack of properly prepared teachers. Without the cooperation of our universities and colleges, we cannot well proceed. With them we can open a new chapter in human progress, human welfare, and human relations.

We already have in existence in our educational institutions a good ground work upon which to build sex education. For example: We have biology which forms the basis of all life; psychology which helps one understand individual drive and mental reactions; sociology which helps our understanding of human relations and helps in the development of the socially efficient person; mental hygiene for the understanding of human conduct and personal relationship; physical education and recreation which helps in developing a healthy and useful citizen, a good potential ancestor, and good sportsmanship; physiology and anatomy for the laws of physical development and good health; home economics centered around home and family living; individual counselling and guidance work, and many other subjects which help to form a good foundation upon which to build a sex hygiene course.

The field is so vast that the entire subject should be reorganized and condensed into a practical textbook which would cover such subjects as:

1. Infancy and pre-school life
2. Mental hygiene of childhood
3. Answering children's questions
4. The teaching of reproduction
5. The pre-adolescent personality
6. Puberty and change of voice
7. The awakening of sex attraction
8. The social life of boys and girls
9. Preparation for maturity
10. Nocturnal emissions

11. Menstruation
12. Masturbation
13. The anatomy and physiology of the male: Testicles, the seminal vesicles, the prostate, and the glans penis
14. Anatomy and physiology of the female; Uterus, vagina, Fallopian Tubes, ovaries, external genitalia
15. The beginning of life: Ovum, sperm, fertilization, embryonic changes, and foetus
16. Venereal diseases: Gonorrhea, syphilis, chancroid, and bubo
17. Ideals of marriage: Common interests, compatibility, rules and regulations, laws pertaining to marriage, the health certificate
18. The part played by the ductless glands

This last item is extremely important. Very few writers on this subject recognize the importance of the endocrine system in social hygiene and human relations. The ovaries, testicles, thyroid, and pituitary occupy the same position in the human body as, for example, the battery in your automobile. As a matter of fact, a small gland about the size of a cherry, located in the little bony fossa known as the sella turcica at the base of the brain midway between the ears, the forehead, and the occipital bone in the back of the head, known as the pituitary gland, is the master gland of the human body. Without it a human being would be an inert mass.

The functioning of the brain, our griefs, happiness, pleasures, energy, love life, size and growth, anatomical development, physiology, human relations, all depend upon this small gland located in the most inaccessible part of the human body. One can scarcely visualize the fact that vast armies, great navies, presidents, kings, and dictators are all under the control of the functioning of this little gland—the pituitary, and yet in a broad sense this is a fact. Unfortunately, the medical profession has not fully developed endocrinology, but what we know thus far certainly plays an important part in human relations.

There are two schools of thought as to the method of teaching social hygiene to elementary and high school children. Maurice A. Bigelow, Professor Emeritus, Teachers College, Columbia University, believes it should be taught as an integral part of the various related subjects, instead of being set up as a separate course. Personally, I believe that social hygiene and human relations should be taught as a separate course and the related subjects used as foundation work. Social hygiene is much more effective and beneficial if

taught in the seventh, eighth, ninth, and tenth grades. We have found from experience that considerable trouble can be avoided by following these simple rules:

1. The course should be given only to girls and boys who want the information and have the approval of their parents.
2. It is of vital importance that the right teachers be selected and the right physician. This is the most difficult part of the program because of reluctance on the part of universities and colleges to properly train teachers. The wrong teacher can do more harm than good.
3. Schedule from six to ten lessons to a semester. Sufficient information for boys and girls can be given in eight well organized lessons.
4. Classes for boys and girls should be conducted separately with approximately thirty boys or girls to a class.
5. Assignments for study, or tests on the subject, should not be given.
6. Classes should be conducted to impart information and it should be made plain that students are attending the class for this purpose, not to obtain credit.
7. Under no circumstances should visitors be admitted to a class.
8. The atmosphere in the classroom should be free, frank, and unemotional.
9. The last class period in the course should be given over to a physician, trained and qualified in sex hygiene and human relations, for answering written questions submitted by the class.

Ignorance on any subject, to say the least, is never commendable. Knowledge acquired through education is the best foundation upon which to build a solid family life. It can be said without fear of contradiction that the aim of all our human activity is to produce a happy human being and a happy family life. How can this be accomplished if we continue to ignore or neglect any subject which vitally affects human relations?

* * * * *

Massachusetts Association of School Physicians,—At a meeting of the interim committee attended by Drs. Mary Moore Beatty, Antonio Milone, Anthony H. Nikiel, Alan Poole, Honoria K. Shine and Allan R. Cunningham, Chairman, and held on September 11th at Hotel Sheraton, Worcester, a draft of the proposed constitution was completed.

Copies of this draft will be mailed to each of the 620 school physicians of Massachusetts and further organization will proceed by meetings of school physicians in each of the eight health districts of the Commonwealth.—*Allan R. Cunningham, M.D.*

TOUCHBALL OR NOT?*

GEORGE W. HANIFORD
Assistant Professor of Physical Education
Purdue University, Lafayette, Indiana

Touch football has long been recognized as one of the more important sports comprising the intramural portion of the nation.

The Western conference intramural directors, at their 1949 meetings, passed a resolution stating: "We believe touch football to be one of the better intramural activities."

However, most directors have noticed that the cry of "Down with intramural touch football" has been increasing in its intensity. Many health service directors either have been, or are becoming, strongly embittered against any form of touch football. They believe the students are not in good enough physical condition to play the game safely. Also, the factor of not having protective equipment is objectionable to them.

The majority of the colleges and universities conducting touch football as an intramural sport have had to face or will face the crisis of either finding a solution to the numerous injuries occurring or eliminating the game from their roster of intramural activities. In the attempt to make the game safer, the majority of the intramural directors have changed many of the game's rules, until today the present game of touch football does not resemble the game of football.

We at Purdue university, in our attempt to make the sport as safe as possible, inaugurated several rule changes; also, the name of the sport was changed from touch football to touchball.

The blocking rule was completely revised, and no blocking is now permissible other than in an upright, erect position. If while blocking a kicked ball, one makes bodily contact with the kicker, it is a foul. On the kickoff, the members of the team receiving the ball may not form interference. If the receiver of the ball from center fumbles it, the ball becomes dead with the loss of a down. When passing the ball, the passer may throw the ball backward, sideward, or forward with all players of the offensive team eligible as pass receivers. Any number of passes are allowed after the ball is put into play by the center, whether or not the person is beyond the line of scrimmage.

These new rules governing the game of touchball were more satisfactory to the health service doctors, even though they objected to any game resembling football.

*Republished from Safety Education, May, 1949, p. 2.

Students as a rule are not very safety-conscious. This was borne out by the attitude immediately adopted by Purdue's student body toward the new game with the various rule changes. They called it a "sissy" game and declared it to be nothing more than a kid's game of keep-away. They wanted bodily contact; they objected to the new passing rule, allowing any number of forward, backward or sideward passes in one down.

Many meetings of the various athletic managers were called. We attempted to indoctrinate them with the new rules. We explained the reasons for their adoption. As a result of these meetings, the students recognized that all the new rule changes were actually inaugurated for their safety as participants.

Intramural touchball, with the new rule innovations, has been conducted for the past several years, with the number and types of injuries varying from year to year. We have noticed that intramural injuries run in cycles. In the year og 1947-48, our total injuries numbered three—one broken arm, one broken collar bone, one sprained ankle. The present year, 1948-49, was a disastrous one, not from the number of injuries, but from the types of injuries. Injuries sustained in our program were: two broken legs, one broken ankle, a double dislocation of the right knee, internal hemorrhage of the right thigh, and a serious shoulder dislocation.

It may be well to add that the two broken-leg injuries mentioned above caused two students to discontinue class attendance for the remainder of the semester. These injuries were all sustained during practice games which precede the start of the regular scheduled contests. As a result of these injuries, intramural touchball was cancelled for the school year 1949-50.

When we cancelled touchball, we anticipated serious objections from the student body; however, instead of objections we received praise. At the fraternity athletic managers' meeting held January 18, 1949, the problem of touchball was discussed. A vote was taken on the following question: "Do you want intramural touchball for next year, 1949-50?" The vote was unanimous: not one fraternity wanted the sport included in its fraternity activities next year.

It will be interesting to observe the reaction of other student bodies in relation to the attitude of the Purdue student body toward intramural touch football or touchball. As one of our broken-leg casualties stated: "In any game of touch football, regardless of the rules, there will be injuries."

The question each intramural director and student body must

answer is: "Do we desire touch football even though we shall anticipate injuries, or do we want to drop the game for a sport of less hazardous nature?" We at Purdue, at least for the present, have answered this question. What is your experience and reaction?

* * * * *

Geographic Restrictions in Admission to Medical Schools,—In the last prewar year out-of-state students constituted 17.4 per cent of the freshman enrollments in the state and municipal schools. During the past academic year the percentage of non-resident students in the freshman classes of these schools was only 8.2 per cent. In the privately owned schools the percentage of out-of-state freshman students for these years were 52.9 per cent and 50.9 per cent, respectively.

While tax-supported institutions might well be expected to render service chiefly to the community that supports them, the exclusion of all non-resident students may not be a real service to the community. The practice definitely narrows the potential area from which a school may seek support.

Students who attend such schools do not experience the stimulation and broadening influence of association with students who have different geographic and educational backgrounds. A most serious consequence of this policy is denial of admission to superior out-of-state applicants in favor of less well qualified residents. As a result, the quality of the medical profession is lowered particularly in the states that follow such a short-sighted policy. The logical extension of this policy is exclusion from schools in other states of students from states in which medical schools exclude non-residents. Again the ultimate effect is reduction of the quality of the medical profession in the states concerned.

Unless this problem can be solved satisfactorily at the local level, strong pressures will be applied at higher levels to dictate admission policies to the schools. Abstracted, Journal—American Medical Association, September 3, 1949, page 92 and Pt.

THE MEDICAL EXAMINATION OF SCHOOL CHILDREN

ALLAN R. CUNNINGHAM, M.D.
Consultant in School Health
Massachusetts Department of Public Health

Because the school examination is so generally spoken of as a "physical examination" and because misapprehension is almost universal among school people and other interested persons, I believe it is well to define exactly what is meant by "physical" examination and assess its importance in the whole examination of any person. A "physical" examination by itself is never a complete examination. The term "physical" qualifies and limits a medical examination to that part of a medical examination which is made of the body of the patient by the physician. In such an examination the physician employs his sense of touch, his vision, his hearing and such mechanical accessories as the stethoscope, electric otoscope, or wooden tongue depressor. But in this part of the examination he does not employ nor regard as a partner the intelligence of the person most concerned—the subject of the study.

It will do us no good in advancing an ideal program of school health to speak of a "complete physical examination" when we mean a complete examination nor will it help to describe it as an "educational procedure" without more accurately assessing such possible educational value at different grade levels. Moreover, in addition to this misconception of the examining function, it is obvious from conversations with many persons interested in health education in the schools that there is a disposition to think of all the so-called "health experiences" in the schools in a vague way, more as an exposure to something catching like measles rather than a considered and guided process. There is quite a difference. Measles is more contagious and runs a more uniform course than any unguided education.

The physician regards a "physical examination" as only a part of a complete examination. Most physicians would regard it as rather less than half. Every physician well knows that the child is not merely a bundle of organs. Were this true, then it would be reasonable to apply machine production methods to expedite school health examinations—one physician would examine the ears, one the heart, one the feet, etc.

The child, of course, is a person. The school physician who fails to recognize this and acquaint himself with this youngster is missing the boat. How terribly handicapped would your family doctor be were he to oblige himself to turn a deaf ear to your

remarks about yourself and draw his conclusions entirely from his physical examination of you. Let me recall to your mind your last visit to your physician. If it was for some reason other than a mere cut finger—some ailment requiring diagnosis or no ailment at all but a periodic checkup, your doctor didn't start examining you immediately. He sat back at his desk with a pen and record form, asked you a lot of questions, wrote down your replies, and regarded your problem with a degree of thoughtfulness before he even unlimbered his stethoscope.

I do not wish to minimize the importance of the physical part of such an examination, but it seems necessary to put it in its true place to counteract the almost universal acceptance of the physical examination as the type of health study to be carried out in the schools. Usually the physician has a pretty good idea of what ails you before he uses his stethoscope at all. The physical examination is merely another source of information. It may be neglected or done carelessly but when it is completed meticulously in addition to the careful and analytical questioning which should precede it, it is a mark of professional character.

As I remarked above, it will be well also more accurately to assess the educational value of the physical examination to the child since the school is primarily an educational institution. We cannot go about describing as of great potential educational value, these examinations without getting down to brass tacks and working out such an educational procedure. An excellent example of such a procedure in the lower grades is found in Chapter VIII of the 1948 revision of "Health Education"—sponsored by the Joint Committee of the N.E.A. and the A.M.A. I will not duplicate that material here.

In later years, with high school students, quite a different approach will be necessary. Let us assume that we are examining a sophomore boy. In this case we will try to discuss with him matters which we know will interest him. We should learn about his home life—what he had for breakfast and how he ate it; about his family and his home responsibilities. "Do you consider yourself as healthy as your friends," we may inquire—"Run as far—good wind —good staying qualities at hard exercise—sleep as well—digest your food—like the girls?" We should learn how he reacts to schools; from which teacher he receives the most inspiration; what are his extra-curricula activities, and finally, what he expects to do when he becomes a family man instead of a high school pupil.

The physician thus becomes a counsellor in ways, some of which superficially may seem unrelated to health but which, in fact,

mother the so-called "total health" of the boy, present and future. Our objective differs sharply from that of the Army Medical Corps especially in the presence of war and our methods must differ correspondingly. The school physician should keep in mind the total objective of school which is to provide a future not only of physical but emotional health, a future in which the boy will find himself well-equipped to take his place in society—to live in great happiness and to develop to the full the potentialities with which he was especially endowed.

Such an examination will be followed by a physical examination in which bodily defects will be noted and explained to the boy. If corrective measures are desirable, the boy at this age should assume the responsibility of having them corrected. Questions relating to sex function are conveniently encouraged and answered at this time, and with regard to all organs of the body the examiner may well make explanatory remarks as he examines heart, lungs, etc., relating his procedures to each. The examiner should self-assess the educational as well as the medical effectiveness of his methods as he proceeds from one youngster to another and attempt to develop his technique in the manner which he finds best suited to encourage the participation of the pupil.

Needless to add, such examinations are necessarily performed in a tranquil manner, not time-wasting but without haste. Six is about enough for one physician in one morning. One at a time, they require the privacy of a physician's office and such should certainly be supplied by the school.

Schools are primarily educational institutions. Since the school physician is cognizant that physical disease, physical defects and their correction are the responsibility of the family physician he will be led properly to view his responsibility not as duplicating that of the family physician but as basically educational. The basic and special responsibilities of the school physician are in fact, to make his health examination an educational experience to the pupil; to prevent and correct conditions menacing to the emotional health of the school child and to search for physical defects.

Both he and the family physician share the responsibility in furthering the emotional health of the school child, the one no less than the other. He should probably seek special training in psychiatric methods to enable him to apply effective measures to prevent emotional ill health and intelligently to screen for further consultative advice such cases as require the care of the specialist. As now he should continue his search for physical disease or bodily

defects to refer them to the family physician if not already under his care or, if known to the family physician but lagging in following his recommendations, to press for sharper action. Obviously such a number three position does not imply that the physical examination should be less than meticulous. As an educational influence the potential bad effects of a careless examination will be greater than the good effects of the most careful one upon these young subjects. It behooves the physician to do a little and do it well rather than to attempt much but do it poorly. Reprinted from News Letter, Massachusetts Dept. Public Health, p. 58, March, 1949.

* * * * *

Unstable Equilibrium of Athletes,—At a meeting of the Medical Society for Physical Education and Sports of Belgium, Dr. Hustin made a report on the Olympic Games in London and pointed out a number of facts to be considered by those responsible for the medical supervision of sports. He pointed out, not only on the basis of interpretation, but on absolutely objective observations, how trained athletes become so specialized biologically that they cannot tolerate the slightest deviation. Every change in food, habits, mode of life and sleep is likely to modify to a noticeable extent their possibilities of performance. Continued training creates a person so artificially and narrowly specialized that in his case we have the right to inquire whether we are not dangerously deviating from the maxim "mens sana in corpore sano".

He discussed the anemia of athletes, which is not widely known, and then proposed to the Belgian Medical Society of Physical Education and Sports a study of the Marathon, with the aim of finding out whether it would not be advisable to omit it from the Olympic program or at least to modify it; the problem of the diet of athletes with regard to the type of sport practiced should also be investigated. Journal, American Medical Association, August 13, 1949, page 1231.

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EDITORIAL

Fall and winter interscholastic sports are again upon us with all that they mean for student spirit and enthusiasm, and, too, all that they could mean for player physical, mental and social benefits.

Unfortunately, there are many schools and many teams where these benefits do not accrue to the extent that they should. There are numerous neglected factors in athletic interscholastic competition that are ignored and neglected.

On the physical side, there is neglect of adequate protective clothing in such a sport as football. In this sport, good protective clothing and devices are expensive. Many smaller and some of the larger high schools cannot, or at least do not, afford to purchase these protections in sufficient numbers. In most of them, there is lack of protection for some of the members of the large squad of contenders that report. This, plus lack of adequate physical conditioning of candidates before scrimmage, is the major cause of the high proportion of physical injuries that occur in the first two or three weeks of the practice and playing season.

Adequate preliminary physical conditioning pays off in fewer injuries, and better playing; speed, accuracy, power, endurance, all are improved.

Most important of all is a lack that is so dangerous that it seems well nigh criminal negligence—namely, the failure of school authorities to provide careful, skilled physical examinations of *all*

candidates preliminary to the start of practice. To be anything like adequate, these examinations should be more than the cursory stethoscopic chest and the inguinal examination. To be really protective, they should include reaction to vigorous exercise, and blood pressure and urinalysis tests, and basic orthopedic standards should be met. Failure to meet successfully these tests and standards should result in exclusion of the candidate from interscholastic athletic competition. This should be a rule of the state department of education and no local superintendent or Board of Education should be permitted to evade it. The examiner should be responsible to the Board, rather than to the Athletic Association or to town "sports".

With careful preliminary physical examination, proper protective clothing and adequate conditioning every candidate will have a good chance of getting through the season without noteworthy injury. Nevertheless accidents do happen. Many of these are potentially dangerous if neglected and some are immediately and extremely dangerous. To protect against these, and to bring about as rapid recovery as possible, the presence on the field of a well trained physician is imperative. Injuries receiving immediate medical and surgical care are likely to be shorter in duration and to have less serious results, than is the case with those neglected or cared for only after the lapse of valuable time. In the treatment of athletic injuries, *"time is the essence"*.

Immediately available, preferably adjacent to the sports field or school physical education plant should be some equipment for first aid and for physical therapy equipment. Those things most valuable for immediate treatment—facilities for thermo-therapy and hydro-therapy—are inexpensive and occupy little space.

To cap the whole; financial protection should be set up. Insurance provisions for the care of expensive injuries that are beyond the purse of the school or Board of Education are a duty. Communities that fail to make such provision for adequate care lay themselves open to the charge that they are more interested in winning games than in educating, training and protecting the youth of the community.—*C.H.K.*

* * * * *

ABSTRACTS AND NOTES

The Challenge of Health Instruction in the Secondary Schools. —*Jean V. Latimer,* Teacher-Training Co-ordinator of Health Education, Massachusetts Dept. Public Health. The responsibility of the school does not rest simply in protecting the health of its pupils while they are in its charge. It also has the responsibility for train-

ing the pupil in health, so that he is prepared to take his place in the world with understanding as to how he should guard his own health, rear a vigorous, healthy family, and use his influence for the betterment of the health conditions of his community. The growing interest in the introduction of direct instruction in health for all students in the secondary schools is an expression of the recognition of these facts. This has come possibly because of the following reasons:

First, it is realized that before health teaching is on a sound basis, it must have a definite and satisfying intellectual content. It must be more than a mere interest in health. While health teaching must be positive, it must nevertheless establish a sound concept of the human machine and its operation on which intelligent health practices and attitudes can be based. Kilpatrick has called the teaching of the "way" of doing things, without teaching the "why" of it, a sleep-walking kind of teaching. He says, "Health habits are all right . . . we need more of them, but we need them knit into understandings and built into the child's very personality, so that he sees, feels, and understands the "why" of it . . . the only way in which you really get health education is by the understanding method . . . it is the only way for a person to fit intelligently into the world, particularly into our modern changing world."[1] We need further educational research in order to ascertain at what age-level health content can most effectively be taught, but it is already evident that there is much factual material which only the older child can grasp, and which must by necessity be left to the secondary schools. But there is general agreement that such areas as mental and emotional health, the role of government in health, personal responsibility for community health, family and social life should be emphasized in the teaching of health in the senior high school.

Second, by making use of the growing scientific curiosity of of the adolescent, we are more likely to continue the interest of the high school pupil in the performance of desirable health practices. The high school boy and girl want to know the underlying facts, but they prefer to make their own investigations, and draw their own conclusions. They are throwing off parental control and beginning to make their own choices as to what they will do about health as well as everything else. These boys and girls want advice, but they do not want advice which is based on sentiment or is threatening. There must be a clear logical reason behind it. We might aim in the secondary schools to take the actual personal life

[1]Proceedings, Sixth Health Education Conferences, Sayville, L. I., p. 5-23, American Child Health Association.

problems of youth and make a definite attack to broaden and enlarge such health interest.

Third, not only have we a challenge for helping youth to build a background on which to base health behavior, but studies and observations in the field would indicate that we have the task of getting rid of the mass of fixed ideas based on health superstitions passed down as a part of the social heritage of family and community life. Again, there is need for counteracting the current widespread misinformation which is constantly being transmitted through printed advertising and the radio. That such propaganda is effective was recently illustrated in a class of high school pupils. When asked the best means of destroying germs, 80 per cent named one of the most widely and unethically advertised products. Again, the fact that 360 million dollars worth of patent medicines are being sold in this country annually,[3] 10 per cent of the total amount spent for all medical services and commodities, is evidence not only of the health interest, but also of the misinformed public.

Moreover, giving youth an insight and appreciation of the scientific method as applied to health education might well be one of the reasons for including health instruction in the secondary school. We must realize that we are dealing with a body of scientific facts, which of themselves do not "stay put" but are constantly changing in the light of a new research. Health facts and their application tend to change, sometimes very quickly but the scientific method which enables the individual to understand and appreciate their applications remains relatively fixed.

If we seek to realize such aims partly through the medium of health instruction, it should be with our eyes open to the fact that health in and of itself is not a subject—it is an objective. Certainly with the growing distrust of verbal learning in itself carrying over into actual conduct, we do not want a revival of the old-fashioned type of structural physiology, which had the pupils give the technical names and numbers of the bones of the body. We do not want these facts taught in and of themselves, but rather an integration of all instruction of the pupils' interests, experiences, and environment in such a way that desirable health outcomes will result.

It is fortunate for us that there is already a movement in the secondary schools for an analysis of the whole process of general education into learning units. This reorganization is taking place because it is recognized that subject matter is not valuable for its own sake, but only as it is serviceable in generating intelligent and useful inclinations and abilities in the pupil. The term "unit" may

[2]Reported in the Journal of School Health, January, 1943.

[3]The Final Report of the Committee on the Costs of Medical Care, p. 29. Chicago, Illinois: University of Chicago Press.

be applied to a series intimately inter-related learnings which involve a definite theme or topic. It may be defined as a larger learning situation which draws on all phases of experience, and makes use of all kinds of subject matter. In it, pupil purposing, planning, executing, and judging are important factors. The approach and interpretation are psychological and therefore flexible; the teacher, however, must conceive of the unit as a more or less logical procedure, starting with definite objectives, carried on through certain series of mental, physical, and social acts, and resulting in specific worth-while outcomes. Obviously, unit organization is more than an outline of subject matter, and certainly it is more inclusive than a project.

In order to develop a better type of health instruction, for several years there has been functioning a joint committee of the Departments of Education and Public Health, which is working towards the goal that eventually a course in direct health instruction, ranging in equal value with other credit courses, will be required of all high school pupils. Abstracted by H. F. Kilander, News Letter, Mass. Dept. Public Health, Oct. 1948.

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Referred Pain,—According to Sinclair and his co-workers none of the existing theories is capable of explaining all the observations which have been made on the subject of referred pain. From recent work on the anatomic mechanisms, underlying various aspects of pain sensibility in the periphery, and on the mode of production of referred pain from the deep somatic tissues of the back, it is postulated that an essential factor in the production of referred pain is the existence of branching among the sensory pathways conveying the sensation of pain. This branching is of such a type that one limb of a branched axon passes to the site of origin of the disturbance, and others pass to the sites to which the pain is referred. This mechanism works in two ways: (1) by leading to a misinterpretation by the central nervous system of the true origin of the pain impulses and (2) by the liberation of metabolities at the terminals in the region where pain is experienced, thus giving rise to secondary pain impulses actually having origin at the periphery. In any given case, both mechanisms are concerned, the first being initially more important than the second, but the second increasing in importance with time and in the later stages preponderating. This theory rests on a basis of currently accepted anatomy and physiology, and is capable of explaining the numerous and sometimes divergent observations which have been made on the reference of pain from both somatic and visceral structures. It may require extension and amplification. Journal—American Medical Association, February 12, 1949, p. 489.

Interscholastic Athletics For Children of Elementary and Junior High School Age,—The Society of State Directors of Health, Physical Education, and Recreation at its annual meeting held this year at Boston, Massachusetts, adopted the following policies concerning interscholastic athletics in the elementary and junior high schools:

1. Reaffirms its strong and unequivocal support of a well-rounded program of instruction in physical education for *all* children and youth.
2. Reemphasizes its interest in and support of interesting, challenging intramural programs for boys and girls of elementary and high school grades in as large numbers as possible.
3. Decries any interschool athletic activity which tends to discourage or limit the development of the instructional or intramural program.
4. Encourages play days and sports days.

In addition to the foregoing, they approved and adopted the following items as statements of interpretation of interschool athletics in the Society's platform for physical education:

Highly organized competitive athletic leagues are not desirable for children and youth of elementary and junior high school age (grades 1-9). Physical education in elementary and junior high schools should stress a well-rounded program of instruction for all children and, for as many as possible, an interesting, extensive program of intramural competition in team, dual, and individual sports supplemented by sports days and play days. In schools where intramural competition is not possible, sports days and play days should be given particular emphasis.

All athletic competition should be conducted in accordance with the needs, capabilities, and interests of growing children.

In addition to the foregoing recommendations concerning interscholastic athletics in the elementary and junior high schools, the Society adopted as a part of the platform the following statement regarding the policy for girls' athletic activities:

All girls' athletic activities should be taught and coached by trained women leaders, and refereed by competent, certified officials, and should be divorced entirely from any interscholastic athletic contests for boys. It is recommended that organized interschool competition for girls be limited and that invitational events, chiefly in the form of sports days and play days, involving mass participation, be emphasized.

Isolation Periods in Communicable Disease,—To the Editor:—What is the latest information on length of quarantine for measles, mumps, chickenpox, whooping cough, scarlet fever and diphtheria? What are the reasons for changing the old periods of quarantine?

Answer—Rigid quarantine regulations are seldom required for the diseases mentioned. However, customary isolation periods are as follows: (1) measles, from the onset of illness until the rash has disappeared: in uncomplicated cases this generally means about 10 days; (2) mumps, until all swelling of the parotid glands has subsided, or eight days from the onset of illness; (3) chickenpox, fourteen days, or until the body is free of all crusts; however, the American Public Health Association has expressed the opinion that varicella is not contagious six days after the appearance of the first lesions, regardless of any crusts that may persist; (4) whooping cough, until three weeks after the beginning of the paroxysmal stage; (5) scarlet fever, a minimum period of fourteen days, but a continuation of isolation if there are abnormal discharges; if the latter persist, until forty-five days when negative nose and throat cultures for hemolytic streptococci should be secured before the patient is released; (6) diphtheria, minimum, seven days or at any time after that when two successive cultures from nose and throat, taken after not less than twenty-four hours apart, are negative for diphtheria bacilli.

Isolation periods are not the same in all states, and consequently the information supplied may be in conformity with public health regulations in one locality but not in another. For some years The American Public Health Association has worked for uniform requirements throughout the country. Changes in isolation periods which are adopted from time to time are based on scientific progress concerning the nature of the acute infectious diseases. Journal—American Medical Association, July 30, 1949, page 1133.

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REVIEWS

"Principles of Health Education," — *Clifford L. Brownell,* Ph.D., McGraw Hill Book Co., Inc., New York, 1949, 366 pages. Price $3.75.

This text deals almost entirely with various phases of the school health services and their organization. One chapter is devoted to the presentation of Health and Safety Instruction.

It contains chapters on Foundations of Health Education; Health Problems; Nature of Growth and Development; Organization of Resources for Health; School Organization for Health;

Health Services and Guidance; Education of the Handicapped; etc.

Covering such a broad spread of content and activities, it is impossible in a text of this size to cover adequately more than a few of them.—*C.H.K.*

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"Teaching Posture and Body Mechanics," *Ellen D. Kelly,* A. S. Barnes and Co., Inc., New York, 212 pages. Price $3.75.

Divided into three parts, Part 1 of this text emphasizes the importance of body mechanics, Part II presents the planning, and organization of the efforts, and Part III, making up the major portion of the text—discusses the Activities to be employed.

The need for a program that will reach all pupils is recognized and the value of preventive efforts is made clear.

This is a good text for the use of physical educators and classroom teachers who see the need of presenting an elementary corrective physical education program.—*C.H.K.*

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The Organization and Administration of Physical Education," *Edward F. Voltmer* and *Arthur A. Esslinger,* Appleton-Century Crofts, Inc., New York 1949, 419 pages. Price $3.50.

This is the second edition of this text which first appeared in 1938. It confines itself practically entirely to the phase of education which its title indicates, although brief discussion is given of the School Health Program outside of Physical Education. After discussing the fundamentals of phases of organization, relation of physical education to general education, aims and objectives of physical education, it presents material on policies and activities, and the physical education service program at various age and grade levels. It has material on the plant and on athletics, and goes into some matters of administration such as organization details, budgeting, purchase and care of equipment, publicity and concludes with chapters on recreation, physical education organizations, and tests and measurements in physical education.

The chapter on aims and objectives is particularly worthwhile, particularly since it analyzes the weaknesses and undesirability of certain "unacceptable objectives". Seldom is this done in a textbook. Authors tends to accept and repeat almost any activity of which they have ever heard.

This is a much better and more analytical presentation of physical education than we usually find. The emphasis is mostly on practical matters and little on vague not well understood theory.

It should be a unit in the library of physical educators and of

school administrators, and read and its practical applications should be used routinely.—*C.H.K.*

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"The Theory of Play,"—*Elmer D. Mitchell, Ph.D.* and *Bernard S. Mason, Ph.D.* A. S. Barnes & Co., New York, 1948, 2nd edition, 542 pages. Price $4.50.

This is not merely a modification of the old text "The Theory of Organized Play" by Bowen and Mitchell, but is a rewritten effort to incorporate the changes of recent years, both in the psychology of play and the changes in the field of recreation that have occurred since the earlier text appeared.

The material is divided into four parts: Historical Background; Theory of Play; The Need of Play; and Administration of Play. Of these the fourth has greatest value to the playground administrator—covering such topics as play promotion, administration of recreation, play areas, clubs, summer camps, school athletics, organization of play activities, and the play leader. It contains much practical usable information which should be readily accessible to physical education and playground directors.—*C.H.K.*

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"Teaching Progressions for the Swimming Instructor,"—*Richard L. Brown,* A. S. Barnes and Co., New York, 1948, 160 pages. Price $3.00.

This teaching handbook, after discussing such bases as qualifications of the instructor, class organization, safety in swimming, etc., analyzes each of the different styles of strokes. Numerous sketches of stroke descriptions help to visualize the strokes and add greatly to the teaching efficiency of the written material.—*C.H.K.*

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MEETINGS

The American School Health Association and the American Public Health Association, New York, N. Y., October 23-29, 1949. Headquarters of the American School Health Association at the Hotel New Yorker.

National Safety Congress, 37th year, at Chicago, Illinois, October 24-28, at the Morrison Hotel.